Annual Cultural Competence Plan

Population Assessment and Utilization Data Objectives

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Ensure *Access to Services* telephone lines are providing linguistically appropriate services to callers. Provide training as needed.	1) Complete a minimum of 36 combined test calls to the Adult Intake Services and Family and Children's Services (Access to Services) telephone lines annually to ensure that staff provides linguistically appropriate services to callers, and are utilizing the Telelanguage Translation Line Service, other provider, and/or TTY.	CLC Committee/ Lead: MHAOD Board QIC/Lead; QI Manager Lead; CSOC Training Supervisor (Jennifer Cook)	MHAOD Board Access to Services Test Line Report; Trilogy E-Learning report.	Due: Annually, by 6/30/17 Completed:
	2) Develop a 24/7 Test call guide for individuals participating in making the test calls.	QI Program Manager; ASOC Analyst (Jennifer Ludford); Kathryn Hill (Sierra County)	New Training guide	Due: 10/01/16 Completed:
	3) Improve documentation of test calls being logged and including all elements from 46% to 70% through distibution of monthly test call findings to AIS and FACS for discussion and ongoing training.	FACS Program Manager (Eric Branson); AIS Contract Monitor; (Curtis Budge); AIS Senior Leadership; QI Program Manager	Monthly distribution of test call finding reports	Due: 06/30/17

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	4). Access/Urgent Care Call Training through annual training	FACS Program Manager (Eric Branson); AIS Contract Monitor; (Curtis Budge); AIS Senior Leadership; QI Program Manager	Power Point Training sign in Sheets	Due: Annually by 01/30/2017
	5) Submit Quarterly 24/7 test call reports to DHCS.	QI Program Manager; ASOC QI Analyst	Call Logs, Completed forms submitted by individuals completing Test Calls. DHCS Quarterly Reports.	Due: Quarterly as requested and in adherence to DHCS quarterly submission timelines. Completed:
Implement the recommendations of the Latino Access Study Update	The specific objectives of the Latino Access Study developed to improve services to the Kings Beach Community are described in the Study. Latino Access Study report to be generated periodically, but the recommendations tracked annually.	Lead: SOC Directors (Maureen Bauman/Twylla Abrahamson (Acting); CLC Manager and SOC Assistant Directors (Eric Branson (Interim) and Marie Osborne)	Written Educational Information	This is an ongoing activity.
	1) Monitor (6 months) the redesigned EHR Assessment implementation, especially the MSE to ensure that the newly identified cultural components are not being used as a default for WNL.	Lead: CLC Manager; SOC Analyst team; IDEA Consulting; QI Manager	AVATAR reports	Due: 06/30/17 Completed:

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Monitor the 3 year training plan as part of CLC Plan requirements taking into account fiscal challenges.	To continue to improve cultural competence and experiences of SOC staff through trainings based on the CLC Plan.	CLC Committee/Lead: CLC Manager; ASOC Training Manager (Kathie Denton); SOC Staff Development/Training Team	CLC Minutes and Staff Development Training Plan	Due: 06/30/17 Completed:
	1) Continue tracking each staff's training attendance to ensure that each staff member participates in a minimum of two training the includes CLC components within the year at a 90% target.	Lead: ASOC Training Supervisor (Chris Pawlak); CSOC Training Supervisor (Jennifer Cook)	Trilogy E-Learning Report for Beneficiary protection, compliance, documentation and billing trainings.	Due: 06/30/17 Completed:
	2) Expand the capacity to conduct Wellness Recovery Action Plan workshops by having the newly identified Train the Trainers, train a minimum of four new facilitators. This goal is continued from last year and was modified from six to four trainers.	Lead: MHA Director (Christi Fee)	MHSA Quarterly Report	Due: 06/30/17 Completed:
	3) Facilitate a minimum of two trainings targeted to increase understanding and responsiveness to diverse cultures.	Lead: CSOC Training Supervisor (Jennifer Cook); ASOC Training Supervisor (Chris Pawlak)	Attendance Records and satisfaction survey report	Due: 06/30/17 Completed:

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Human Resources Composition Objectives				
Assess bilingual staff and interpreter skills and provide training	1) Provide annual training for staff regarding use of interpreters, including use of the Language line, accessing TTY for hard of hearing/deaf indivduals through elearing trainings. Increasing from 92% to 95% attendance.	CLC Committee/Lead: CLC Manager; ASOC Training Manager (Kathie Denton)	CLC Minutes; Training Flyer, sign-in sheet	Due: 06/30/17 Completed:
Continue to create opportunities for consumer advocates, family advocates, Consumer Navigators, and Peer Advocates, to attend and feel welcomed at SOC Meetings, including QIC, CCW, CLC; leadership meetings, etc.	1) Ensure participation of the same above in formal performance improvement projects such as the System Improvement Project (SIP) for CWS, and Performance Improvement Plan (PIP) for Mental Health.	CLC Committee/Lead: CLC Manager/QI Manager SIP Manager QI/QA Supervisor	SIP and PIP workgroup membership	Due: 06/30/17 Completed:
	2) Continue to include Consumer/Family member participation (whenever possible) on employee hiring interviews. Target – 15%. This goal is continued from the previous year.	Lead: SOC Assistant Directors (Eric Branson (interim) and Marie Osborne)	Tracking of participation	Due: 06/30/17 Completed:
	3) Continue to provide opportunity for Consumer Liaison to review and provide feedback on letter templates and brochures that may be used to distribute information to consumers. A minimum of two brouchures will be reviewed.	Lead: ASOC Assistant Director (Marie Osborne) and Consumer Liaison/Supervisor.	List of documents review by Consumer Liaison/Patients' Rights Advocate	Due: 06/30/17 Completed:

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	4) Development and Implementation of the Family Inclusion policy and practices (AB1424).	Lead: QI Manager; MHA family advocates; MHADB Adult Subcommittee.	Development of Policy and form from Workgroups.	Due: 03/01/17 Completed:
Track staff participation in trainings and presentations.	Further implement and develop monitoring tools for training through Trilogy Inc., E-Learning training module for all SOC staff.	CLC Committee/Lead: CSOC training supervisor (Jennifer Cook) and ASOC training supervisor (Chris Pawlak) for listed goal areas.	Trilogy reports of staff attendance - baseline year	
	1) Continue to monitor required internal trainings in e-learning to ensure 90% SOC compliance depending on target audience for the following: Compliance Training (all staff), Beneficiary Protection Training (clinical and admin support staff), and Documentation and Billing Training (MH staff only).			Due: 06/30/17 and onoging Completed:
	2) Monitor tracking report and review at CSOC leadership meetings. Periodically review ASOC tracking reports to ensure ASOC trainings are being monitored at least bi-annually (Org Leadership and Sups/Mgrs./Seniors Meetings).		Minutes of CSOC and Tracking reports for ASOC.	Due: 06/30/17 and ongoing Completed:

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1.2 SOC Managers and Supervisors will create tools and guidelines for successfully integrating cultural curiosity and awareness as a system-wide practice.	1) Sustain a training team to assist staff with integrating values and behaviors.	Lead: CSOC Training Supervisor (Jennifer Cook); ASOC Training Supervisor (Chris Pawlak).	SOC Staff Development Team meetings being held and minutes produced.	Due: On-going Completed:

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	2) Monitor adherence to the CLAS Standards across the MH Providers. This goal is continued from last year and was modified focus on MH Providers.	Lead: ASOC Assistant Director (Marie Osborne); QI Program Manager; QI SUS Supervisor	MH Provider meeting Minutes, Completion of two by MH Organizaitonal Providers who have site certifications.	Due: 03/01/17 Completed:
	3) Include Cultural Concepts of Distress within the clinical documentation manual. Continuation from previous years goal.	Lead: ASOC Assistant Director (Marie Osborne) and QI Supervisor (Derek Holley).	Documentation Manual	Due: 06/01/17 Completed:
2.1 SOC leadership will increase cultural diversity in policy making and governance processes.	Re-establish the Consumer Council that was started as part of the Welcome Center and Cirby Club House to create opportunities for consumers to give direct feedback to SOC leadership teams on areas of system operation and improvements. Counsumer Council to meet a minimum of two times. This goal is continued from previous year and has been modified.	Lead: MHA Consumer Affairs Coordinator/Supervisor; MHA Director.	Council minutes	Due: 06/30/17 Completed:
2.2 SOC Managers and Supervisors will take a strengths based approach to policy development that promotes involvement of consumers and line staff.	(2.2.2) Increase accuracy of indicators for cultural representation of consumers in mental health services by ensuring completion of the CSI fields in AVATAR.	Lead: MIS (Pete Hernandez); ASOC Analyst Jennifer Ludford; CSOC Analyst; ASOC Admin Tech (Andy Reynolds); Program Managers	Decrease in the number of CSI errors identified on Monthly CSI error reports.	

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	1) Continue to work with Netsmart and AVATAR work group and data entry staff to strengthen the accuracy of CSI data as it is inputted into system.			Due: 12/31/16 and monitored quarterly.
3.2 SOC Staff will integrate multi-cultural and multi-lingual communication strategies into a community-based model of care.	1) Continue to Integrate Native American/American Indian and Latino services Team into CSOC through maintaining a minimum 90% of appropriate referrals ending up on the service correct team. 2) Participate and track state effort to link probation, child welfare, and mental health data bases to also link to CSI data to track data.	Lead: CSOC Interim Assistant Director (Eric Branson); SNA Director (Anno Nakai); LLC Director (Carlos Quiroz); CLC member/Analyst (Debbie Bowen-Billings). Lead: CSOC Analyst (Sara Haney); AVATAR team	Statistics on percentage of correct referrals created and reviewed quarterly.	Report due: 06/30/17 Completed: Due: Ongoing Completed:
4.1 Human Resource Development: Expand the skills, experiences and composition of SOC human resources to better serve consumers from diverse cultures and communities	1) Require service delivery, supervisory and management staff to participate in a minimum of two culturally relevant training each year. This may include trainings that have culturally responsiveness included in the training.	Lead: SOC Staff Development Committee	Report on percent participation	Due: Ongoing Completed:

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	2) Continue to review and revise forms (e.g. Intake, assessment, treatment plans, probation terms and conditions, FRCC referrals), for language translation and cultural needs and coordinate with EMR implementation.	Lead: CLC Committee; EHR Committee.	Revised forms being implemented	Due: Ongoing Completed:
	3) Complete Back Translation for documents (forms/fliers) to ensure accuracy.	Language World Contract Monitors (Jennifer Cook and Marie Osborne), QI Committee members, Form Committee Chair (Derek Holley).	Record of documents reviewed as part of the *back translation* verification.	Due: 06/30/17 (ongoing) Completed:
	4) Workers will document efforts to engage cultural brokers and community partners when working with families of diverse cultures in progress notes with 25% accuracy. This goal is continued from previous years.	Lead: SOC supervisors to train their staff to include; QI Team to revise chart audit tool to include elements to check.	Monitor of AVATAR report to identify when translation services were provided and documented into progress notes; revised chart audit tool to track adherence.	Due: 06/30/17 Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	5) Increase identification of Cultural brokerage in progress notes. This goal is continued from previous year.	Lead: MIS (Pete Hernandez), and ASOC Assistant Director (Marie Osborne), Crystal Report Writer.	AVATAR Report. Add Question related to use of Cultural Broker being used in EHR progress note.	Due: 04/01/17 Completed:
	6) Continue to conduct Native Training similar to Tribal Star for staff and community partners with 75 members in attendance.	Lead: SNA Director (Anno Nakai)	Sign In Sheets	Due: Annually Completed:
4.5 Client Sensitivity Training is an annual required training for all staff.	Provide annual opportunities for Client Sensitivity Training or activities two times a year. May be implemented by Speaker's Bureau activities and trainings, outside trainings, Director's Forums, community events, etc.	Lead: QI Manager; CLC Committee; MHA Director ; Consumer Affairs Coordinator; Youth Manager.	Quarterly training opportunities and rosters, Trilogy tracking system	Due: Annually by 06/30/17 Completed:
5.3 Improve service sites and waiting areas to be more welcoming of diverse populations	Convene a workgroup of Supervising Administrative staff, CLC Committee members, and family and youth advocates to assess the improvement needs and implement the necessary changes to make Cirby Hills waiting area more diverse and welcoming.	Lead: Administrative Sups (Debbie Longhofer, Susan Kirkwood), MHA Director (Christi Fee), Youth Manager; Jainell Gaitan (ASOC Program Supervisor); MHA Consumer Liaison.	Consumer Satisfaction Survey or Welcoming Survey results indicate that waiting rooms are more inviting.	Due: 03/31/17 Completed:

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6.1 SOC Managers will work in partnership with community-based organizations to support the development of best practices for community advocacy services.	1) Monitor submission of Program Outcome tools from Organizational providers and report out results annually.	Lead: MHSA Program Manager and Coordinators; QI Manager; ASOC Admin Tech; SOC Analysts and Program Managers.	Quarterly reports being completed and sent in Annual report of Outcome Tools	Due: Quarterly and ongoing. Completed:
6.2 Contract providers will be culturally competent.	Continue to track, review and quarterly reports for MHSA contractors for monitoring of recruitment, training and retention of a culturally and linguistically competent staff.	Lead: MHSA Manager (Kathie Denton); MHSA Supervisor (Jennifer Cook).	Quarterly and annual provider reports; site visits	Due: 06/30/17 and ongoing Completed:

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Performance Improvement Projects				
Improve access and timeliness of services.	Review, modify and track timeliness to services to bring SOC in alignment to the HEDIS measures	QI Manager and Team	Administrative PIP; Work group minutes	Due: 12/31/16 Completed:
Continue Systematic Changes that enhance Health Care Integration through level of care/transitions to PCP.	Monitor the implementation of the LOCUS throughout the ASOC through utilizaiton of Data to determine clients that can be safely transition to a Health home for Mental Health services. Coordination with MCP regarding referrals to and from MCP to MHP and visa versa through sharing of referral tracking form on a monthly basis.	Lead: ASOC Asst. Director Lead: ASOC MH Supervisor; CSOC MH Supervisor; Representatives from MCP plan	Various including LOCUS embedded into the EHR; and final report. Referral Tracking form and quarterly meeting minutes.	Due: Semi Annually reports. Due: Quarterly and ongoing.
Ongoing Implmentation of the LOCUS	Increase number of Adult Consumers who have received a LOCUS rating/evaluation at time of treatment planning from 2% to 10% by end of FY. Monitor correlation of Level of Services received by Adult Consumers and their LOCUS score.	Lead: ASOC Assistant Director, QI Manager, AVATAR team, ASOC Analyst, ASOC Program Managers.	Development of LOCUS report Development of LOCUS Report that will identify clients LOCUS Score and compare score with level of services	Due: Annually and ongoing Due: Annually and ongoing

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Continue process of combining PIP and SIP process for crossover issue monitoring.	Create a joint mental health, child welfare, foster care nursing, and information technology workgroup to explore and monitor the psychotropic medication usage in the foster care population for Placer County, compare that to state usage, and intervene as deemed clinically reasonable and necessary while also improving internal systems and the accuracy of this monitoring.	PIP Workgroup/ Lead: CSOC Acting Director (Twylla Abrahamson); QI/QA Supervisor (Derek Holley); CSOC Interim Assistant Director (Eric Branson).	On-going Clinical PIP	Due: 03/01/17 Completed:
SUS Performance Improvement Plans	Begin to develop methods within the EHR to track timeliness for SUS Services	SUS PIP Workgroup/Lead: QI Manager, ASOC Manager, ASOC Analyst	Development of PIP tracking tools	Due: 6/30/2017 Completed:

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Service Delivery System Capacity				
Continue to monitor and develop capacity to engage and provide services to Latino families, specifically in South County (e.g. Lincoln) per service delivery system capacity geographic distribution study.	Increase the use of Cultural Brokers into the Adult System of Care in Auburn and Roseville MH/SUS services by 100% (increase from 1 to 2).	Lead: ASOC Managers (Amy Ellis, Curtis Budge, Kathie Denton); Latino Leadership Council; ASOC Supervisors (Scott Genschmer, Csilla Csiszar and Jainell Gaitan).	Cultural Brokers operating with ASOC	Due: 06/30/17 Completed:
Develop Mental Health Service Capacity (Groups) based on an analysis of System Service Gap (on-going activity).	Network Providers offer some groups for youth and adults open to Medi-Cal beneficiaries.			
	1) Continue to collect and disseminate group list offered by internal staff, Network Providers, Partners Agencies, and community providers on a quarterly basis.	Lead: Provider Liaison; QI Manager	Group list created and disseminated quarterly	Due: Ongoing Completed:
	2) Maintain the number of groups offered through Adult Mental Health and Substance Use Programs at 30 per year.	Lead: ASOC Manager (Amy Ellis), ASOC Supervisors (Scott Genschmer and Lisa Sloan)	Group attendance, Avatar reports; ASOC Group Calendar.	Due: Ongoing Completed:

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	3) Determine current baseline of service needs for ASOC upon the implementation of the LOCUS. Use the information provided to determine if there are any gaps in treatment services and make a plan to address.	Lead: ASOC Leadership; AVATAR IT workgroup, SOC QA committee	LOCUS outcomes	Due: 6/30/17 Completed:
Develop System Service Capacity in targeted geographic locations (Tahoe and South County) based on results from community planning process and service capacity study.	Campaign for Community Wellness (MHSA Community Planning process) and service capacity study indicated needs for Tahoe and South County.	Lead: Lead: PEI Supervisor (Jennifer Cook)		
	1) Ensure contractors continue measuring outcomes for all projects. (See CSS/PEI Local Evaluation Goal).	Lead: CSOC MHSA Supervisor (Jennifer Cook); MHSA/SOC Evaluator (Nancy Callahan)	Annual MHSA PEI/CSS Report; quarterly reports	Due: Ongoing Completed:
	2) Track progress and feedback from the community through quarterly and annual reports and CCW presentations and surveys.	CSOC MHSA Supervisor (Jennifer Cook); SOC Evaluator (Nancy Callahan)	Outcome reports	Due: Ongoing Completed:
	3) Complete the MHSA Outcomes/Evaluation Report for community and the BOS.	Lead: SOC Evaluator (Nancy Callahan); CSOC Interim Director (Twylla Abrahamson)	MHSA Outcomes Evaluation report	Due: 03/30/17 Completed:
	4) Complete annaul geographical analysis of W&I 5150 detentions to determine if there are gaps in treatment services.	Lead: ASOC Analyst (Jennifer Ludford); Admin Tech (Andy Reynolds).	Completed geographic analysis of W&I 5150 detainments.	Due: 11/30/17 Completed:

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Accessibility of Services/Timeliness of Services				
Test responsiveness of the 24/7 access to services telephone line(s) including both the toll free and local lines.	1) Increase number of test calls from 13 to 36 made to either the Adult Intake Services and Family and Children's Services (access to services) telephone line/s for 24/7 responsiveness at 100% effectiveness. 2) Increase the number of test call that are logged by 10% in the AVATAR Call Log and the AVATAR Quick Call Log through additional testing by the QI/QA Team and dissemination of monthly test call results to AIS and FACS leadership. FY15/16 Baseline was 6 of 13 (46%) were both logged and included the name of the caller and 9 of 13 (69%) recorded the date of the test call.	Testing Lead: MHAOD Board; QIC/ Lead: QI Manager; ASOC Analyst, ITT (Pete Knutty) Lead: QI Manager; QI/QA Supervisor (Derek Holley), Admin Tech (Andy Reynolds); AIS and FACS leads.	MHAOD Board Access to Services Test Line Report AVATAR Call Log and Quick Call Log; Quarterly DHCS Reports	Due: 06/30/17 (Annual) Completed: Due: 06/30/17 (Annual) Completed:
Provide timely Access to after hours care	Monitor access to after hours care by tracking response times for Mobile Crisis Team and request for W&I 5150 evaluations through Quarterly reports.	Lead: QI Manager, ASOC MH Crisis Services Manager, ASOC Analyst, FACS and AIS Contract Managers.	5150 MOU data and MCT data	Due: Quarterly Completed:

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Provide timely access to services for urgent conditions and post hospitalization.	Monitor timely access to services:	Lead: CSOC Acting Director (Twylla Abrahamson) and ASOC Asst. Director (Marie Osborne); Lead for each workgroup includes CSOC Manager (Candyce Skinner); CSOC Supervisor (Derek Holley); team members include ASOC analysts, IT members, program members and QI/QA staff.	Workgroup has been operational to determine the correct AVATAR episodes to extract data from, such as episode (3) Telecare PHF to either episodes (12), (251), (254), 251, or (248)	
	1) Decrease number of acute admission episodes that are followed by a readmission within 30 days during a one year period, defined as January 1 – November 30 (NCQA/HEDES)/ by 4.5% (from 44 to 42 readmissions). Baseline data: 44 readmissions within 30 days. This goal has been modified to track percentages rather than number of acute admissions. For FY15/16: 79 of 706 (11.2%) individuals who received treatment in acute hospitalizations were readmitted within 30 days of discharge. Goal is to decrease by 2% to 9.2%.		Tracking data sheet statistics	Due: 06/30/17 and ongoing Completed:

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	2) Improve percentage of acute [psych inpatient and Psychiatric Health Facility (PHF)] discharges that receive a follow up outpatient contact (face to face, telephone, or field) or IMD admission within 7 days of discharge (NCQA/HEDIS) by 5%. Baseline data: 62% of PHF discharges had an outpatient contact within 7 days. Baseline data for IMD Admission not available. FY15/16 improved this by 14%, with 536 of 705 (or 76.0%). Goal is to increase percentage from 76% to 81%.			Due: 06/30/17 and ongoing Completed:
	3) Improve percentage of acute [psych inpatient and Psychiatric Health Facility (PHF)] discharges that receive a follow up outpatient contact (face to face, telephone, or field) or IMD admission within 30 days of discharge (NCQA/HEDIS) by 5%. Baseline: 65% of PHF discharges with an outpatient contact within 30 days of discharge. Data for IMD admissions was not available. For FY15/16- 568 of 705 (or 80.0%) of individuals being discharged from an acute psychiatric facility and psychiatric health facility (PHF) received a follow up outpatient contact (face to face, telephone or filed based) or IMD admission within 30 days of discharge. This is an increase of 15% over previous year's baseline. Monitoring of this standard will continue with goal to achieve 85%.			Due: 06/30/17 and ongoing Completed:

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	4) Develop new access and timeliness reports upon completion of the Episode Gap Analysis	AVATAR Team; Timeliness Workgroup	Timeliness Reports	Due: 04/01/17 Completed:
Provide timely access to services for non-urgent conditions		Lead: CSOC Interim Director (Twylla Abrahamson) and ASOC Asst. Director (Marie Osborne); Lead for each workgroup includes SOC Program Managers, SOC Analysts, team members include ASOC analysts, IT members, program members, and QI/QA staff.	Timeliness workgroups are being formed to determine the correct AVATAR episodes to extract data from,	
	1)Continue to refine system through the GAP Analysis that will allow for better tracking of outcomes.	Timeliness workgroup; IT Gap Analysis Workgroup.	Timeliness workgroup minutes and Gap Analysis minutes.	Due: 02/01/2017
	2) Conduct intake assessments and other services in a timely manner within SOC in an integrated manner through the development of a drop in clinic for MH screening and assessments.		ASOC Program Manager, Amy Ellis	Due: 02/01/17

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	3) Improve percentage of non-urgent mental health service (MHS) appointments offered within 10 business days of request of the initial request for an appointment (DHCS request) by 10%. Baseline data for SOC combined is 51%. FY15/16 data was at 70% for ASOC and 30% of the children/youth who requested services were documented as having been offered an appointment, however, 100% of children/youth who were offered an appointment were offered an appointment within this timeline. This data discrepancy appears to have been a data entry challenge as we rolled out this new process. Including the data entry error, the SOC overall exceeded the goal at 62%. The goal is to improve the overall percentage by 10% to 72%.	Timeliness Workgroup	AVATAR reports	Due: 06/30/17 Completed:
	4) Improve timeliness of non-urgent mental health service (MHS) appointments offered within 15 business days of request of the initial request for an appointment (CMHDA recommendation) to monitor by 10%. Baseline data (FY14/15) for SOC Combined was 57%. FY15/16 the SOC combined total was at 81%. Goal for this year is to increase percentage from 81% to 86% overall.	Timeliness Workgroup	Avatar Report	Due: 06/30/17 Completed:

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	5) Track average length of time between first non-urgent mental health services (MHS) and offered initial psychiatric appointment. Previous data had been pulled from actual date of service not date offered. ASOC average was 58 days while CSOC was 1 day. CSOC considers the request for a psychiatric appointment, once the family has completed all of the necessary paperwork and obtained a complete H&P by PCP, including an EKG. Combined the SOC average length of time was 44 days. Goal is to decrease ASOC length by 10% (58 days to 52.2 days).	Timeliness Workgroup	Avatar Report	Due:06/30/17 Completed:
	6) Track percentage of non-urgent medication support appointments offered within 15 business days of the request from an appointment (CCR). The percentage of medication support services offered within the expected timeframe, varies greatly between the two Systems of Care. This variance was due to the difference in how this is operationalized by the SOC. CSOC considers the request for a psychiatric appointment, once the family has completed all of the necessary paperwork and obtained a complete H&P by PCP, including an EKG. For ASOC, the percentage was 5%, for CSOC the percentage was 100%, with an overall percentage being 23%. Goal is to improve the ASOC percentage by 5% to 10%.	Timeliness Workgroup	AVATAR Reports	Due: 06/30/17 Completed:

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	7) Continue to track and monitor the length of time between referral call and completed assessment appointment with goal being under 14 days.	Timeliness Workgroup	AVATAR Reports	Due: 06/30/17 Completed:
	8) Continue to monitor Monitor length of time from Dependency Mental health screening data on the Mental Health Screening Tool (MHST) to date of assessment appointment (Katie A requirement).Goal is reduce length of time for >5 from 47 days to 43 days and for ≤ 5 from 35 days to 30 days.	Lead: CSOC Manager (Candyce Skinner); CSOC Analyst; AVATAR IT team	AVATAR reports	Due: 06/30/17 Completed :

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		Client Satisfaction		
Maximize Consumer satisfaction responses to the State CPS/POQI for quality improvement purposes.	Gather data from county service site/s and available contract service provider sites (ACOC: Cirby Hills; SMWG: Roseville, Auburn, and Tahoe; Turning Point; and Sierra Forever Families).	Lead for all tasks: Consumer Specialist Program Supervisor (Chris Pawlak); ASOC Program Manager (Amy Ellis); QI Manager MHA Consumer Affairs Coordinator; QI Supervisors.	DHCS Client Perception Survey IData	
	1) Continue to utilize Consumer Specialists to administer Performance Outcome Screen instruments to clients.	ASOC Manager (Kathie Denton); ITT (Pete Knutty).	Consumer Perception Survey results.	Due: This is an on-going activity; Completed:
	2) Decrease number left blank from a baseline of 34% in 2008, a high of 47.7% in 2012, 22% in 2013, 30% in 2014 and 30.5%. The two CPS in fiscal year 15/16 idicated 18.89% and 30.7% of survey's were left blank for an overall percentage of 25.95%. Target for FY16/17 is 25%.	ASOC Manager (Kathie Denton); ITT(Pete Knutty).	Consumer Perception Survey results.	Due: 06/30/17 Completed:
	3) Conduct Welcoming Survey if State does not mandate use of the CPS/POQI.	QA Team; ITT (Pete Knutty).	Welcoming Survey results if conducted.	Due: TBD

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Identify and implement new survey for use by MHADB regarding client satisfaction.	To obtain client satisfaction data annually from English-speaking adult and child clients/legal guardians on behalf of child using SOC designed evaluation tool.	Lead: MHAOD Board QIC; QI Manager; QI/QA Supervisor (Derek Holley)	MHAOD Board or delegated Survey Results	
	1). Identify new survey tool for use by MHADB.			Due: 01/01/17
	2) Determine percentage of English speaking respondent's who complete new MHADB survey.	ITT, QI Manager, QA Supervisor, Assistant Director of CSOC		Due: 05/01/17 Completed:
	3) Determine percentage of Non English speaking respondents who complete new MHADB survey.	ITT, QI Manager, QA Supervisor, Assistant Director of CSOC	MHAOD Board or delegated Survey Results	Due: Annually: 06/30/17 Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Review and monitor client grievances, appeals and fair hearings, and 'Change of Provider' requests for trends (ongoing).	1) To identify trends and take necessary actions in response for both internal SOC, Organizational Providers, and Network Providers	Lead: Patients' Rights Advocate (Lisa Long) and QI Manager	Grievance/Appeal change of provider report w/trends	Due: 10/31/16 Completed:
	2) Review annual report with QI and CLC Committees	Lead: Patients' Rights Advocate (Lisa Long)	Submission of Annual Report, QIC minutes	Due: 10/31/16 Completed:
	3) Increase staff and provider knowledge regarding beneficiary protection through annual training taken through the E-Learning Trilogy system with a minimum of 90% compliance with training.	Lead: Patients' Rights Advocate (Lisa Long); SOC Training Supervisors (Jennifer Cook and Chris Pawlak); QI/QA Supervisor (Derek Holley)	Beneficiary Protection pre-post tests	Due: 06/30/17 Completed:
Review and monitor to ensure Program Integrity through Service Verification (ongoing)	1) Randomly select 5% of all mental health service claims from a given month for both ASOC and CSOC. Send verification letters to each beneficiary with instructions to call the Patients' Rights Advocate if the beneficiary did not receive the listed service or services.	Lead: IT (Pete Knutty); Analyst (Jennifer Ludford); Admin Tech (Andy Reynolds)	Monthly Service Verification letter and tracking database compilation	Due: Quarterly reports. Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Service Delivery System and Clinical Issues Affecting Clients				
Bi-monthly medication monitoring at MD meeting / Medication Review Committee by random review of a sample of client charts (ongoing).	To promote safe medication prescribing practices, and to evaluate effectiveness of prescribing practices.	Medication Monitoring Committee / Lead: Medical Director (Olga Ignatowicz, MD)	Bi-annual Medication Monitoring report to QIC Report	
	1) Track number of charts with no deficiencies and increased from a baseline of 50% to 60%. During the past year, the number of charts without deficiencies hit an all time low of 33% .	Medication Monitoring Committee / Lead: Medical Director (Olga Ignatowicz, MD)		Due: 06/30/17 Completed:
Ensure regulatory and clinical standards of care for documentation are exercised across the system of care (SOC)	1) Review a minimum of 10% of ASOC non-medication only Medi-Cal charts (ASOC baseline determined by point-in-time 7/1/15) and 20% of CSOC Medi-Cal charts in which the client/consumer received a mental health service through peer review committee meetings at each clinic site. Report at QIC.	QI/MCU Lead for all tasks: QI/QA Supervisor (Derek Holley)/QI Manager; EHR Committee	Quarterly Compliance UR Report	Due: 06/30/17 Completed:
	2) Chart review will indicate compliance with 90% of all chart review indicators for both ASOC and CSOC. Fiscal year 15/16 data indicate ASOC did not achieve 90% compliance in the three indicators, CSOC was incompliance with 2 of 3 indicators.	QI/MCU Lead for all tasks: QI/QA Supervisor (Derek Holley)/QI Manager.	UR Report	Due: 6/30/17 Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	3) Update annual clinical documentation training and provide to contract providers, Tahoe, Sierra County, ASOC/CSOC and Network Providers in an on-line format and disseminate and track for 95% clinician and provider completed post-tests.	QI/MCU Lead for **all** tasks: QI/QA Supervisor (Derek Holley)/QI Manager.	Training Handouts/Post-test report	Due: 12/31/16 Completed:
	4) Monitor implementation of new audit tool to assist with monitoring documentation practices within the EHR.		Training sign in sheets; Outcomes from chart reviews.	Due: 03/31/17 Completed:
	5) Upon completion of new Assessment, SOC will implement a paper version of the new Assessment for use by Organizational and Network providers.		New Assessment tool for both Network and Organizational Provviders.	Due: 06/30/17 Completed:
	6) Revised Clinical Documentation Manual.		Documentation Manual	Due:03/31/17 Completed:
	7) Revised Policies and Procedures Manual.		Completed Revised Policies and Procedure Manual	Due: 06/01/17 Completed:
Redesign of the W&I 5150 training and crisis evaluation process.	1) Update Crisis evaluation to include components of AMSR and modify training.	Lead: ASOC Crisis Services Manager, ACR leads and PRA.	Revised crisis evaluation form and updated training.	Due: 12/31/16 Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
		Provider Relations		
Ensure Network Provider compliance with Medi-Cal regulations, documentation guidelines, and quality of care through training and auditing.	1) Report on trends quarterly at the QIC Meeting through formal report.	Lead for all tasks: QI Manager; Provider Liaison QI/QA Supervisor (Derek Holley); and ITT/MIS (Pete Knutty)	Network Provider quarterly trend reports; NP Training Tracking Tool; Provider List; Power point training	Due: 06/30/17 Completed:
	2) Conduct provider audits twice per month and hold Network Providers to the standards created for corrective action at 90% adherence.	MH Audit Team clinicians; QA Support (Judi Tichy).	Network Provider Audit monitoring database.	Due: 06/30/17 Completed:
	3) Conduct 100% annual audits for all Organizational Providers. Ensure 90% accuracy for all indicators.	MH Audit Team clinicians; QA Support (Judi Tichy).	Organizational Provider Audit monitoring database.	Due: 06/30/17 Completed:
	4) Hold Documentation, Billing and Compliance training annually in the on-line format; track compliance, and de-activate providers for non-compliance.	Lead for all tasks: QI Manager; Provider Liaison QI/QA Supervisor (Derek Holley); ITT (Pete Knutty); QA Support (Judi Tichy).	Trilogy E Learning database.	Due: 06/30/17 Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Monitor and communicate results of Network Provider satisfaction with the Placer County internal systems.	1) Complete Network Provider satisfaction survey annually and compile results. Increase response rate from 23.4% in 2016 to 55%; baseline 47%, with prior year's 37.7%, 29.57%, 36.7%, 25.5%, 15.3%, and 13.6%.	Lead: QI Manager and IT/MIS (Pete Knutty)	Annual NP Satisfaction Report; Network Connection newsletter; Behavioral Managed Care Website	Due: 6/30/17 Completed:
	2) Use Provider Newsletter "Network Connection" and MCU Website to communicate results both internally and externally after survey results are compiled.	Lead: QI Manager; Network Provider Liaison and QI/QA Supervisor (Derek Holley)	Network Connection Newsletter.	Due: 06/30/17 Completed:
Build upon Community Collaboration with Organizational providers	Facilitate Quarterly MH Provider meetings.	Lead: ASOC Assistant Director Marie Osborne; SOC Program Manager.	Quarterly meeting minutes	Due: Quarterly Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Child Welfare Services – System Improvement Plan				
Special Note: On October 10, 2014, the Administration for Children and families (ACF) issued a new Federal Register notice (79FR 61241) that provided notice to all states to replace the data outcome measures used to determine a state's conformance with Title IV-B and IV-E of the Social Security Act. On May 13, 2015, ACF published a correction to the Final Rule in the Federal register (80 FR 27263).The 17 federal data outcomes measures have been replaced, updated, or eliminated to produce a total of seven (7) new data outcome measures and will be tracked accordingly in the FY16/17 Workplan.				
P5-Placement stability (former C4.3 Placement Stability-24 months in care)	National Standard: > 41.8% Current Performance: <4.12 (32.9%) Target Improvement Goal: 41.8%	Lead: CWS Court Unit Manager (Tom Lind), SIP Consultant (Nancy Callahan), Probation Manager (Nancy Huntley)	Berkeley Quarterly Report AB 636 Measures	Due: 06/30/2017– annual update due Completed:
Priority Outcome Measure or Systemic Factor: 2C Timely Social Worker Visits with Child	National Standard: 90% Current Performance: 93.% up from 78% in the prior reporting period. Target Improvement Goal: increased to 95%	Lead: CWS Court Unit Manager, SIP Consultant (Nancy Callahan), Probation Manager (Nancy Huntley)	Berkeley Quarterly Report AB 636 Measures	Due: 06/30/2017–annual update due. Completed:
Priority Outcome Measure or Systemic Factor: 2F Timely Social Worker Visits with Child-In residence	National Standard: 50% Current Performance: 74.2% up from 63.7% in the prior reporting period Target Improvement Goal: 50%	Lead: CWS Court Unit Manager, SIP Consultant (Nancy Callahan), Probation Manager (Nancy Huntley)	Berkeley Quarterly Report AB 636 Measures	Due: 06/30/17- annual update due
Priority Outcome Measure or Systemic Factor: 4 B Least Restrictive Placement	National Standard: None Current Performance: Current Performance is 91.7% placed in group home and 8.3% in foster home. Target Improvement Goal: No more than 50% probation youth (Title IV-E) in group home care; at least 50% in relative, NREFM or foster care homes.	Lead: CWS Court Unit Manager , SIP Consultant (Nancy Callahan), Probation Manager (Nancy Huntley)	Berkeley Quarterly Report AB 636 Measures	Due: 06/30/2017– annual update due Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Priority Outcomes Measure of Systemic Factor: 4E Placement of American Indian Children	National Standard: None Current Performance: 47% of ICWA children placed in Native foster homes, compared to 6% of Native foster children are placed in Native relative placements; and Multi-Cultural American Indian children in placement has improved from 28 to 35 or an increase of 31.4%. Target Improvement Goals: a) Increase the percentage of Native children who are correctly identified in the CWS/CMS from 75% to 85% by year 3. We have had an increase from seven (7) to 15 for ICWA eligible children placed with relatives between the baseline (SIP) and January 2015, for a 114% increase. b) Increase % of Native relative placements for Native children to 30% by end of year 5. Baseline was 28 placed with relatives and in January 2015, we had 35 children in relative placement for an increase of 31.4%. Goal: continue to monitor c) Increase # of Native placement homes from 2 to 10 by end of year 5.	Lead: CWS Court Unit Manager, SIP Consultant (Nancy Callahan), Probation Manager (Nancy Huntley)	Berkeley Quarterly Report AB 636 Measures	Due: 6/30/2017 – annual update due Completed: Goal: 06/30/17 Completed: Due: 06/30/17 Due: 06/30/17 Complete:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	1) Maintain the current practice of monitoring CWS cases to ensure that SOP practices on the entry and ongoing CWS teams are provided in a minimum of 80% cases.	Lead: CWS On-Going Services Manager (Eric Branson); FACS Supervisor (Miranda Lemmon)		Due: 06/30/16 Completed:
Child Welfare Core Training Requirements to be enhanced to Common Core (align with Core Practices Manual and Process via Katie A)	A workgroup will be formed to practices and policy related to new Common Core.			
	1) Monitor Implementation of CWS Training Plan to ensure method to implement training practices continue to be compliance with Common Core. *Note: New standards for Common Core are still being defined by CDSS and UC Davis Training Academy so processes are still being developed as this occurs*	Lead: CSOC Training Director (Jennifer Cook); CSOC Training Committee	Identification of trainings that include Common Core.	Due: 06/30/17 Completed: Goal was met.
Child Welfare Case Reviews	Complete 70 Child Welfare Case reviews	Lead: CSOC CWS Program Manager, SOC QA staff	Reports	Due: 06/30/17

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Substance Use Services – Quality Management Plan Extract				
Enhance Substance Use Provider Monitoring	1) Complete 10 site reviews and report outcomes reports within 14 days of visit. 2) Submit 100% County DMC Monitoring Corrective Action Plans to DHCS within 14 days of receipt.	Lead: QI Supervisor; QI Manager; ASOC Asst. Director Lead: QI SUS Supervisor	SUS QA site review reports SUS QA site review reports	Due: 06/30/17 Completed: Due: As needed, reported semi annual Completed:
Increase timeliness and accuracy of CalOMS and DATAR reporting	1) Continue to ensure 90% of CalOMS data errors are corrected within 30 days of submission. 2) Continue to ensure 95% of Provider DATAR reports are submitted within 30 days of due date	Lead: QI Program Manager; SUS Program Manager; QI Admin Tech (Andy Reynolds). Lead: ASOC Admin Tech.	Review of data and monthly reports to providers. Review of data and monthly reports to providers.	Due: 06/30/17 Completed: Due: 06/30/17 Completed:
SUS contract providers will demonstrate use of CLAS Standards	1) QI team will monitor Providers for training to CLAS Standards. Goal: 80% of providers reviewed will demonstrate evidence of training. 2) QI team will monitor Providers implmentation of CLAS Standards. Goal: 100% of providers reviewed during this year, will complete CLAS Standard Monitoring tool.	Lead: SUS Program Manager; QI/QA Supervisor; Asst. Director ASOC Lead: SUS Program Manager; QI/QA Supervisor; Asst. Director ASOC	Lead: SUS Program Manager; QI/QA Supervisor; Asst. Director ASOC Lead: SUS Program Manager; QI/QA Supervisor; Asst. Director ASOC	Due: 06/30/17 Completed: Due: 06/30/17

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Increase in QA monitoring of SUS Providers and ability to serve PWD.	1) Amdend CSI form to include types of disabilities.	Lead: Forms Committee	Modified form	Due: 09/01/16
	2) SUS Program Clerks will begin entering Question #16 from CSI sheet into Avatar E H R. No current baseline for this data.	Lead: SUS Program Clerks.	Increase entry into Electronic Health Record.	Due: 07/01/16
	3) Develop an AVATAR Crystal Report that will allow QA and SUS program leadership to analysis if the array of SUS services are meeting the needs of PWD.	Lead: AVATAR team, ASOC Analyst, SUS Program Leadership.	New Crystal Reports Geographical Map	Due: 09/30/16
	4) Complete Analysis of PWD and geographical locations of SUS providers to assess needs.	Lead: AVATAR Team, ASOC Analyst, SUS Program Leadership	Geographical Map and calculation of percentages of providers/needs.	Due: 04/30/2017

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	5) Increase QA monitoring of SUS Providers ability to serve PWD through Development of Checklist for Accessiblity and implementation of this tool by Providers.	Lead: QA SUS Supervisor	Providers who receive a site review during FY16/17 will complete tool as part of review	Due: 06/30/17
	6) Facilitate a discussion of provider referral mechanisms and current regulations pertaining to serving PWD is planned for the September 2016 Provider Meeting.	Lead: QA Sus Supervisor	Meeting Minutes	Due: 09/30/16
Monitoring of Provider Quality Assurance Program.	Providers will submit annual QI plan and a minimum of semi annual updates.	Lead: SUS Program Supervisor	Report of percentage of providers in compliance. Goal is 75%.	Due: December, 2016 and June 2017.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
SUS Preperation of Implementation of DMC-ODS				
Network Adequacy	Through an RFP process, develop and establish contracts with SUS Providers to ensure an array of services are available in geographical locations.	Leads: SUS Program Manager, QA Program Manager	RFP Contracts Analysis of current Providers location, ASAM level and needs of Medi-Cal beneficiaries	Due: 06/30/17
24/7 Access line	1) Establish a 24/7 toll free phone number for access to ODS services with language capacity. 2) Establish methods for testing access to access line.	Leads: SUS Program Manager, QA Program Manager Leads: SUS Program Manager, QA Program Manager. MHADB	24/7 Access Line for SUS Services Development of Test Call procedures	Due: 06/30/17 Due: 06/30/17
Authorization and Denials	2) Develop methods and establish timelines for decisionss related to service authorizaitons, including tracking the number, percentage of denied, and timeliness of request for auithorizaitons for all DMC-ODS.	Lead: SUS Program Manager, QA Program Manager, AVATAR team	Crystal report	Due: 06/30/17

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Grievance and Appeals	Develop internal grievance process that allows a beneficaiary or provider on behalf of a beneficary to challenge a denial of coverage services or denial of payment.	Lead: QA Program Manager	Grievance/Appeals Policy and Procedure	Due: 06/30/17
Care Coordination	1) Establish MOU with Managed Care plans 2) Develop a structure approach to care coordination to ensure transtiion between levels without disruption.	Lead: SUS Program Manager Lead: SUS Program Supervisor	MOU Care Coordination Guidelines	Due: 12/30/17
Implementation of EBP	1) Provide trainings on ASAM Criteria for determing Level of Care for SUS treatment. 2) Monitor SUS Provider to ensure at least two evidence based Pratices (EBP) are being followed. EBP include: Motivational Interviewing, Cognitive Behavioral Therapy, Relapse Prevention, Trauma Informed Treatment, and Psycho-educational groups.	Lead: SUS Program Manager, SUS Program Supervisors, QA, AVATAR Team Lead: SUS Program Manager, SUS Program Supervisors, QA, AVATAR Team	Established guidelines for care coordination MOUs with MCP plans ASAM Trainings AVATAR Reports	

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Timeliness and Access to Services	1) Establish method to determine timeliness of first initial contact to face-to-face appointment (number of days to first ODS services after referral). 2) Establish method to determine timeliness of services of the first dose of NTP services.	Lead: SUS Program Manager, SUS Program Supervisors, QA, AVATAR Team Lead: SUS Program Manager, SUS Program Supervisors, QA, AVATAR Team	Timleiness Report Timelinss Report	
Client Satisfaction Survey	Develop method to complete Assessment of beneficiaries' experience	Lead: SUS Program Manager, SUS Program Supervisors, QA, AVATAR Team	Survey	

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
In Home Supportive Services – Quality Management Plan Extract				
To ensure IHSS rules and regulations are being adhered to and to ensure IHSS recipients receive services according to the guidelines set forth in CDSS IHSS policies.	1) Conduct 297 IHSS Desk Reviews using the uniform task guidelines and other IHSS monitoring tools.	Lead: QI/QA Supervisor (Derek Holley); QI/QA IHSS Reviewer (Lee Vue) for all goals listed.		Due: 6/30/17 Completed:
	2) Conduct 59 QA Home Visits.	Lead: QI/QA Supervisor (Derek Holley); QI/QA IHSS Reviewer (Lee Vue) for all goals listed.	Home Visit Tool	Due: 06/30/17 Completed:
	3) Complete 1 Targeted Review.	Lead: QI/QA Supervisor (Derek Holley); QI/QA IHSS Reviewer (Lee Vue) for all goals listed.	Targeted Review submission	Due: 06/30/16 Completed: Goal was met on 04/01/16. The targeted review was reviewing the SOC332 form for initial and reassessment to determine level of compliance. Sixty cases were reviewed and all (100%) found to be compliant.
	4) Complete unannounced Homevisits as requested by DHCS.	Lead: QI/QA Supervisor (Derek Holley); QI/QA IHSS Reviewer (Lee Vue) for all goals listed.		Due: 06/30/17

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
	5)QA will monitor the Quality Improvement Action Plan as imposed by CDSS to ensure that IHSS reassessments are completed for an average of 80% of IHSS recipients annually. Baseline for FY15-16 was 51%; FY15-16 was 79.58%. (not 79.06 %).	Lead: QI/QA Supervisor (Derek Holley); QI/QA IHSS Reviewer (Lee Vue) for all goals listed.	Reassessment tracking and CDSS information	Due: 06/30/17
	6) Compile quarterly reports and review at QIC and HHS Compliance meetings.	Lead: QI/QA Supervisor (Derek Holley); QI/QA IHSS Reviewer (Lee Vue) for all goals listed.	QIC and HHS Compliance meeting minutes	Due: Quarterly Completed: 06/30/16
Overpayment collections	Finalize all related processes for the collection of IHSS overpayments.	Lead: QI/QA Supervisor (Derek Holley); QI/QA IHSS Reviewer (Lee Vue) for all goals listed.	Letters Due Process Guidelines	Due: 03/01/17
To monitor and detect activities that appear to be fraudulent in nature.	1) Continue to conduct Fraud Triage as necessary on 100% of potential fraud complaints. Refer to Medi-Cal internal Special Investigations Unit (SIU) for fraud investigation or to program for administrative action.	Lead: QI/QA Supervisor (Derek Holley); QI/QA IHSS Reviewer (Lee Vue) for all goals listed.	CDSS SOC 2245 Fraud Report	Due: 06/30/17 Completed:

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
helping people	***Sierra County Quality Management Goals***			
Ensure Access to Services telephone lines are available 24/7 and provide linguistically appropriate service to callers. Provide training as needed.	1) Test the Health and Human Services phone service a minimum of 15 episodes to ensure staff and after-hour messages are linguistically appropriate in directing callers to appropriate services. 2) Utilization of DCHS approved phone tree narrative protocol will be implemented for Access Line	1.MHSA Coordinator (Laurie Marsh) 2. Assistant Director of BH (Kathryn Hill)	Mental Health Advisory Board (MHAB) Members to test telephone line access to services during hours of business and after hours.	Due: Quarterly, by June 30, 2017 Completed: Contracts with Telelanguage, Spanish speaking interpreters and services for deaf and hard of hearing were established and/or renewed. County has completed rewiring of phone line infrastructure.
Expansion of peer support services to address service needs county wide.	1) Two additional peer support specialists will be hired and training will be implemented. Specialists will be placed in both Loyalton and Downieville locations. 2) Increase in open hours of Loyalton Wellness Center to four days a week.	1) MHSA Coordinator, (Laurie Marsh)	1) Tracking of participation, trainings peer support specialists have participated in. 2) Tracking of participation, peer run activities, and MHSA Annual Update evaluation data.	1) Due: 6/30/17 Two peer support specialists have been hired and training has begun commiserate with job description and duties. 2)Due: 12/01/16 Completed: With addition of new peer support specialist hires anticipated increase in Wellness Center hours will be completed by 12/01/16.

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date / Completion Date
Initiate telepsychiatry services in order to provide full spectrum psychiatric services for beneficiaries residing in both the east (Loyalton) and west (Downieville) areas of the county.	1. Vendor and affiliated physician will which meet the specific demographic and cultural needs of Sierra County residents will be identified and contracts with be signed by BOS. 2. Technological infrastructure will be purchased and installed. 3. Staff will be trained to implement the appropriate protocols to implements services. 4. Beneficiaries will be educated and supported throughout transition.	1)Assistant Director of BH (Kathryn Hill), 2) IT specialist (Tim Jordan).	1) Contract between Sierra County and Vendor will be completed. 2) All technological will be purchased and installed. 3) Utilization of telepsychiatry services will be notated in EMR of beneficiary.	1) Due: 9/15/16 2) Anticipated Launch date: 11/15/16
Initiate Veterans Support Services	Hire Veterans Peer Support Specialist and implement training commensurate with job description and duties	1. MHSA Coordinator (Laurie Marsh) 2. SCHHS Assistant Director (Lea Salas)	1) Needs assessment will be completed and job description will be constructed appropriately. 2) Specialist will be hired and training will commence commensurate to job description & duties.	